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No. 96-

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1996

Aetna Health Plans of California, Inc., *et al.*,

Petitioners,

v.

William Ardary, *et al.*,

Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

Stuart M. Gerson
Counsel of Record
William A. Helvestine
Michael T. Horan
David M. Pierce
Epstein Becker & Green, P.C.
1227 25th Street, N.W.
Washington, D.C. 20037
(202) 861-0900
Counsel for Petitioners

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QUESTION PRESENTED

Whether state law actions seeking both Medicare benefits determinations and consequential damages are preempted by Congress' command of exclusive administrative jurisdiction contained in the federal Medicare Act.

PARTIES TO THE PROCEEDING

Petitioners, Aetna Health Plans of California, Inc., Aetna Life Insurance Company, AHP Holdings, Inc., Aetna Health Management, Inc., and Judith Hendrix (collectively, "Aetna"), were part of a group of the litigants designated as the appellees below.

Aetna Health Plans of California, Inc., is a wholly-owned subsidiary of Aetna Health Management, Inc. which, in turn, is a wholly-owned subsidiary of AHP Holdings, Inc. AHP Holdings, Inc., in turn, is a wholly-owned subsidiary of Aetna Life Insurance Company which, in turn, is a second-tier, wholly-owned subsidiary of Aetna, Inc. Aetna, Inc. is the surviving entity of a merger of corporations which brought about the corporate dissolution of co-defendant/co-appellee below Aetna Life & Casualty Company. Partners Acquisition Company, another co-defendant/co-appellee below, was once wholly owned by Aetna Health Management, Inc., but was dissolved as a result of a merger with its parent corporation. Judith Hendrix is a marketing representative for Aetna.

Respondents William Ardary, Diane M. Houston, Kevin Ardary, and William C. Ardary, MD, were the appellants below. They are the surviving family members of Cynthia Ardary, a Medicare beneficiary, whose claim gave rise to this action.

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PETITION FOR WRIT OF CERTIORARI

Aetna respectfully petitions for a writ of *certiorari* to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit, as amended on denial of rehearing and rehearing *en banc*, is reported at 98 F.3d 496 (1996), and is reprinted in the Appendices ("App.") at 1a-13a.

The unpublished opinion of the United States District Court for the Central District of California is reprinted at App. 14a.

JURISDICTION

The judgment of the United States Court of Appeals for the Ninth Circuit was entered on October 21, 1996. Petitioners timely filed a Petition for Rehearing and Suggestion for Rehearing En Banc, which was denied on December 26, 1996. At that same time, the Court of Appeals amended its October 21 opinion to correct a misstatement. This Court has jurisdiction to entertain this petition pursuant to 28 U.S.C. § 1254(1).

PERTINENT STATUTORY PROVISION

The jurisdictional bar of the Medicare Act, as incorporated by 42 U.S.C. § 1395ii, provides in pertinent part:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as provided herein. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover any claim arising under this subchapter.

42 U.S.C. § 405(h).

STATEMENT OF THE CASE

This case arises from the alleged wrongful denial of Medicare benefits. Because Respondents' complaint would require the state court to make a Medicare benefits determination, the cases arises under the Medicare Act and is thus subject to the exclusive jurisdictional provisions of that statute.

A. The Medicare Benefits Determination

Respondents are the surviving family members of the late Cynthia Ardary. App. at 2a. Mrs. Ardary was a Medicare beneficiary enrolled in Aetna's Senior Choice HMO plan under a contract with HCFA to provide Medicare major medical and hospitalization benefits under the health plan. *Id.* at 2a. On May 9, 1993, Mrs. Ardary suffered a heart attack, and was removed to the Bear Valley Community Hospital. *Id.* Aetna allegedly denied a preauthorization request for coverage for an air-lift transfer to Loma Linda Hospital. *Id.* at 2a-3a. Respondents attribute Mrs. Ardary's death to Aetna's decision to deny coverage. *Id.* at 3a.

B. The Ardary Complaint

However, Respondents never filed an appeal or other complaint within appropriate administrative channels regarding the determination that Medicare benefits were not available for the emergency airlift. *Id.* at 3a. Rather, on January 25, 1994, Respondents sued in California state court seeking consequential and punitive damages on the basis of six state-law tort theories. *Id.* at 3a & n.3.

Although Respondents drafted their complaint so as not to assert a claim for payment of Medicare benefits, they nonetheless conceded that their claims were all "predicated on"

the determination that Medicare benefits were unavailable for the emergency airlift. *Id.* at 3a-4a. In their brief to the Court of Appeals, Respondents asserted that

> [i]t is critical to note in this context that the wrongful death action is predicated on the allegation that the benefits were, in fact, owed and were, in fact, wrongfully denied. Moreover, the plaintiffs in such an action will also be required to demonstrate, at trial, that the wrongful denial of [Medicare] benefits was the proximate cause of the death.

Id. at 4a n.4 (citing Ardarys' Brief to the Ninth Circuit at 20-21).

C. The District Court Proceedings

In February 1994, Aetna and a co-defendant timely removed the state court action to federal court, asserting federal question jurisdiction under the Medicare Act. *Id.* at 4a. On March 4, 1994, they moved to dismiss the complaint for failure to state a claim, on the ground that the Ardarys' exclusive remedy for an action "predicated on" the denial of Medicare benefits was the administrative process set forth at 42 U.S.C. § 405(h). *Id.* The district court granted the motion to dismiss on May 26, 1994, and Respondents timely appealed. *Id. See also id.* at 14a (setting forth the District Court opinion and order).

D. The Ninth Circuit Proceedings

On October 21, 1996, the Ninth Circuit reversed the district court's order, holding that the Ardarys' claim did not "arise under" the Medicare Act. 98 F.3d 496 (1996) (App. at 1a-13a). The court held that the jurisdictional bar of § 405(h) did not preempt the jurisdiction of state law over Respondents' claims where such claims did not explicitly seek recovery of Medicare benefits, but rather sought compensatory and punitive damages under state law. *Id.* at 499-501 (App. at 6a-13a).

The Ninth Circuit described the issue in this case as a "thorny jurisdictional question" which is "[w]ithout clear guidance from the Supreme Court or Congress." *Id.* at 501 (App. at 11a). In making its substantive determination, the Ninth Circuit relied on this Court's decisions in *Weinberger v. Salfi*, 422 U.S. 749 (1975) and *Heckler v. Ringer*, 466 U.S. 602 (1984). The Ninth Circuit also expressly rejected the decision and the rationale of the United States Court of Appeals for the Seventh Circuit as expressed in *Bodimetric Health Services, Inc. v Aetna Life & Casualty*, 903 F.2d 480, *cert. denied*, 498 U.S. 1012 (1990).

Citing *Salfi*, the Court held that the Medicare Act did not provide Respondents with the "standing and substantive basis for the presentation of the claims" against the Medicare system because "the standing for [Respondents' claims were] state common law theories and not the [Medicare] Act." 98 F.3d at 499-500 (App. at 8a). Citing *Ringer*, the Ninth Circuit held that Respondents' claims were not "inextricably intertwined" with the denial of Medicare benefits because they did not seek recovery of such Medicare benefits. *Id.* at 500 (App. at 8a-9a). Citing *Bodimetric*, the Ninth Circuit objected to the Seventh Circuit's reasoning and its conclusion that § 405(h) preempts the jurisdiction of state law over cases predicated on a denial of Medicare benefits, but which also seek

consequential damages under such state law. *Id.* at 500-01 (App. at 9a-11a).

Aetna filed a petition for rehearing and suggestion for rehearing *en banc* on November 4, 1996, which were denied on December 26, 1996. *See id.* at 496 (App. at 1a) (noting the Ninth Circuit's denial of rehearing and rehearing *en banc*). On December 31, 1996, Aetna filed an application for a stay pending its petition to this Court, which application was granted on January 28, 1997. *See* App. at 15a (setting forth the Ninth Circuit's stay order).

REASONS FOR GRANTING THE WRIT

I. THE NINTH CIRCUIT'S DECISION FLATLY MISAPPLIES THIS COURT'S PREEMPTION DECISIONS IN *WEINBERGER V. SALFI* AND *HECKLER V. RINGER*.

The jurisdictional preemption provision of the Medicare Act, as incorporated by 42 U.S.C. § 1395ii, provides that "[n]o action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover any claim arising under this subchapter." 42 U.S.C. § 405(h). Under this provision, judicial review of a claim arising under the Medicare Act is available only after the claimant exhausts his or her administrative remedies. *Heckler v. Ringer*, 466 U.S. 602, 605 (1984). Section 405(h) thus preempts either federal court or state court jurisdiction over claims "arising under" the Medicare Act until after the claimant exhausts available administrative remedies before HCFA.

In *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975), this Court defined claims "arising under" the Social Security Act, of which the Medicare Act is a part, as those claims for which "both the standing and substantive basis for the presentation" of the claim is the Social Security Act, even for those claims simultaneously arising under some other point of law. In *Ringer*, 466 U.S. at 613-16, this Court held that claims "arising under" the Medicare Act are claims for which the requested relief is "inextricably intertwined" with a claim for Medicare benefits, even for those claims which assert no express request for the payment of such benefits.

The Ninth Circuit's decision flatly misapplies these two standards by rejecting the notion that a claim concededly "predicated on" a Medicare benefits determination is not

automatically a claim "arising under" the Medicare Act. This Court's intervention is necessary to redirect federal caselaw to the course it set in *Salfi* and *Ringer*.

A. The Ninth Circuit's decision misapplies this Court's "standing and substantive basis" standard set forth in *Salfi*.

Salfi involved a claim for widows' and childrens' benefits under the Social Security Act, which mandated an irrebuttable presumption that wives or step-children of less than nine months of age, were not entitled to dependents benefits. *See* 42 U.S.C. § 416(c), (e). A widow who had been married to the deceased wage earner for six months brought suit challenging the irrebuttable presumption as unconstitutional. *Salfi*, 422 U.S. at 753. A three-judge district court panel concluded that it had federal question jurisdiction and that the statute was unconstitutional. 373 F. Supp. 961 (N.D. Cal. 1974). This Court reversed, holding that the district court was barred from taking federal question jurisdiction by the jurisdiction preemption provision of 42 U.S.C. § 405(h). 422 U.S. at 761.

The Salfis argued, however, that their claim was not barred by the jurisdictional preemption provision of § 405(h) because their claim arose under the Constitution, and not under Title II of the Social Security Act. *Id.* at 760. The Court found some merit in the argument, stating that "[i]t would, of course, be fruitless to argue that [the Salfis'] claim is one which does not arise under the Constitution, since their constitutional arguments are critical to their complaint." *Id.* The Court determined, however, that the Salfis' claim nonetheless also

"arose under" the Social Security Act because "it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions." *Id.* at 760-61.

In so holding, the Court subsumed as a matter of common sense that any point of law "critical to" the presentation of a claimant's arguments is a point of law under which the claim arises, or at least draws its core essence. By holding that the Social Security Act provided both the "standing and the substantive basis" for the Salfis' claims, the Court relied on the notion that the Salfis' entire cause of action was predicated on the fact that the Salfis had presented a claim for benefits under the Social Security Act. *Id.* In short, the Court reasoned that although constitutional caselaw defined the constituent elements of the Salfis' cause of action, the Social Security Act served as the very underpinning for the presentation of the claim and thus governed the claim.

The Ninth Circuit's decision ignored this reasoning in distorting this Court's "standing and substantive basis" standard. In cursory and erroneous fashion, the circuit court determined simply that because "the standing for [Respondents'] claims are state common law theories and not the [Medicare] Act," the Medicare Act did not provide the "standing and substantive basis" for the Respondents' claims within the meaning of *Salfi*. 98 F.3d at 499-500 (App. at 8a). As such, the Ninth Circuit failed to grasp that the *Salfi* standard extends beyond a mere reference to the elements of a particular cause of action, but rather includes consideration of the legal environment in which a claim is asserted. In light of Respondents' own concession that their claims are "predicated on" the denial of benefits under the Medicare Act, the Ninth Circuit's determination clearly throws off course this Court's *Salfi* "standing and substantive basis" standard.

This standard necessarily contemplates a broad interpretation of the phrase "arises under" to enforce faithful adherence to the jurisdictional preemption provision of § 405(h). Under *Salfi*, § 405(h) "extends to any 'action' seeking 'to recover on any (Social Security) claim' -- irrespective of whether resort to judicial processes is necessitated by discretionary decision of the Secretary." 422 U.S. at 762 (emphasis supplied). *See also Schweiker v. Chilicky*, 487 U.S. 412, 425-29 (1988) (Congress, through its establishment of a limited review process, has provided the remedies it deems necessary to effectuate the Medicare claims process). The Ninth Circuit's decision simply ignored *Salfi's* reasoning and provided Respondents with an end-run to a more fortuitous forum -- a state court jury trial for consequential damages -- but which has been precluded by Congress nonetheless. This Court's intervention is thus necessary to redirect federal caselaw back to the course it set in *Salfi*.

B. The Ninth Circuit's decision misapplies this Court's "inextricably intertwined" standard set forth in *Ringer*.

Ringer, decided nine years after *Salfi*, involved the challenge of four Medicare beneficiaries to a Medicare policy denying coverage for a particular surgical procedure. 466 U.S. at 607-08. The beneficiaries asserted no claim for Medicare benefits, but only for declaratory and injunctive relief. *Id.* at 610-11. The district court dismissed the complaint in its entirety for lack of jurisdiction, finding that any challenge the beneficiaries raised to the policy were "inextricably intertwined" with their claim for benefits. *Id.* at 611-12.

The Ninth Circuit reversed the district court, holding that because the beneficiaries' challenge asserted no claim for Medicare benefits theirs was a challenge to the Secretary's

procedure for determining entitlements to benefits and thus fell outside § 405(h). 697 F.2d 1291, 1294 (1982). This Court reversed, holding that the beneficiaries' challenge arose under the Medicare Act and was thus barred by § 405(h). 466 U.S. at 613-16.

The beneficiaries there had argued that because they sought only declaratory and injunctive relief and not the payment of Medicare benefits, their challenge was not "inextricably intertwined" with a specific Medicare benefits determination. *Id.* In response, this Court reaffirmed the broadly-interpretive *Salfi* "standing and substantive basis" standard, stating that "[i]t is of no importance that respondents here . . . sought only declaratory and injunctive relief and not an actual award of benefits as well." *Id.* at 615. Rather, this Court determined that the beneficiaries' claim was, despite the stylings of the prayer for relief, a claim that they should have been paid for the surgery and thus was a claim predicated on a Medicare benefits determination governed by § 405(h). *Id.* at 614-16.

This Court's holding laid down the principle that the relevant statutory language "to recover on any claim arising under [the Medicare Act]" is to be construed "quite broadly" to sweep within its scope even those challenges in which the claimant does not seek payment of a Medicare benefits claim. *Id.* at 615. Under this principle, although the relevant statutory language speaks in terms of "recovery" and "claims under the Medicare Act," a challenge predicated on an adverse Medicare benefit determination, even a challenge asserting no claim for such benefits, is a challenge fundamentally grounded in the Medicare Act and thus governed by § 405(h).

The Ninth Circuit's conclusion that Respondents' claims "are not 'inextricably intertwined' [with a Medicare benefits determination] because [Respondents] are at bottom not seeking

to recover benefits," 98 F.3d at 500 (App. at 8a-9a), is flatly at odds with this Court's holding in *Ringer* that "[i]t is of no importance that respondents . . . sought only declaratory and injunctive relief and not an actual award of benefits as well." *Ringer*, 466 U.S. at 615. Again, in light of Respondents' own concession that their claims are "predicated on" the Medicare Act, the Ninth Circuit's determination impermissibly narrows this Court's traditionally broad interpretation of those claims "inextricably intertwined" with an adverse Medicare benefits determination.

The Ninth Circuit also suggested that a claimant's challenge does not "arise under" the Medicare Act where the claim is "wholly 'collateral' to his claim for benefits, and where he [makes] a colorable showing that his injury could not be remedied by the retroactive payment of benefits. . ." 98 F.3d at 500 (App. at 9a) (citing *Ringer*, 466 U.S. at 618). This too misapplies *Ringer* in that this standard governs the determination of whether a claimant must fully exhaust his administrative remedies, not of whether his claim "arises under" the Medicare Act. *See id.*, 466 U.S. at 618 (limiting the application of the exception to the exhaustion of remedies requirement for cases arising under the Medicare Act). *See also Mathews v. Eldridge*, 424 U.S. 319, 330-32 (1976) (claimant's deteriorating physical condition and dependency upon disability benefits suggested that an erroneous administrative termination of benefits would damage him in a way not recompensable through retroactive payments).

In ignoring the mandate that *Ringer* requires a broad, rather than narrow, reading of those cases "arising under" the Medicare Act, the Ninth Circuit's decision impermissibly restricts the grant of preemption authority incorporated in § 405(h). Again, this Court's intervention is thus necessary to restore the effect of *Ringer*.

II. THE NINTH CIRCUIT'S DECISION HAS CREATED A SPLIT AMONG THE CIRCUITS AS TO WHETHER STATE LAW ACTIONS SEEKING BOTH MEDICARE BENEFITS DETERMINATIONS AND CONSEQUENTIAL DAMAGES ARE PREEMPTED BY FEDERAL LAW.

With regard to the question presented in this case, the conflict between the Ninth Circuit's decision here and the Seventh Circuit's decision in *Bodimetric,* 903 F.2d 480 (7th Cir.), *cert. denied*, 498 U.S. 1012 (1990), could not be more direct and apparent. In its *Bodimetric* decision, the Seventh Circuit determined that § 405(h) preempted state law jurisdiction over a case in which the plaintiff sought consequential damages based on the defendant's alleged wrongful administration of Medicare benefits. In the instant case, the Ninth Circuit determined that § 405(h) did *not* preempt state law jurisdiction over a case based on state law theories of recovery. This Court's intervention is thus necessary to resolve the split created by the Ninth Circuit's decision in this case.

A. The Ninth Circuit's decision conflicts directly with the Seventh Circuit's decision in *Bodimetric*.

In *Bodimetric*, a case also involving an Aetna-related entity, the plaintiff owned and operated home health agencies ("HHAs") that provided in-home medical services and obtained Medicare reimbursements for medical services rendered from its fiscal intermediary, Aetna. 903 F.2d at 482. In 1985, Aetna allegedly began to deny improperly Bodimetric's applications

for reimbursement so that Aetna could improve its contract performance evaluation with HCFA and thereby assure renewal of the contract. *Id.* Bodimetric sued Aetna, seeking damages for fraud and other state law causes of action. *Id.* at 483.

Aetna successfully moved to dismiss the complaint for lack of subject matter jurisdiction, alleging that the jurisdictional preemption provision of § 405(h) barred Bodimetric from pursuing its challenge in federal court. 706 F. Supp. 619 (N.D. Ill. 1989). On appeal, the Seventh Circuit affirmed the district court's order on the basis that the action "arose under" the Medicare Act and was thus barred by § 405(h). 903 F.2d at 487.

Bodimetric had argued that its claim was not barred by § 405(h) because its specific claims arose under state law, and not under the Medicare Act. *Id.* The Seventh Circuit, however, made short shrift of Bodimetric's arguments, holding that

> [a] party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for consequential damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely [bypass § 405(h)] by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined.

Id. Essentially, the Seventh Circuit rejected Bodimetric's argument that because it sought damages from Aetna's own pocket and not from the Medicare Trust Fund, its claims could

not be characterized as "inextricably intertwined" with a Medicare benefits determination and thus governed by § 405(h). *Id.* at 484.

In the instant case, the Ninth Circuit disagreed openly with the Seventh Circuit's reasoning and held that because Respondents do not seek reimbursement for benefits *per se* but couch their claims in terms of consequential damages, their claims do not "arise under" the Medicare Act. 98 F.3d at 500-01 (App. at 9a-11a). In repudiating *Bodimetric*, the Ninth Circuit stated that the Seventh Circuit's reasoning "certainly [does] not suggest, at least to this court, that [the Seventh Circuit's statement of the law] is the standard for making the critical judgment call about what 'arises under' the [Medicare] Act." *Id.* at 501 (App. at 11a).

In short, the Seventh Circuit pierced the veil of the pleadings and saw Bodimetric's claims (as this Court commanded) for what they were: claims predicated on the outcome of a Medicare benefits determination. In direct contrast, the Ninth Circuit here accepted Respondents' claims at face value and refused to consider the indispensable role of the Medicare Act in framing Respondents' entire cause of action. As Respondents concede, this case cannot be decided without having the state court decide whether Medicare benefits were wrongfully denied, a decision expressly and exclusively delegated to the jurisdiction of the HCFA administrative appeals process. This Court's intervention is thus necessary to resolve the split among the courts of appeal.

B. The division in the Courts of Appeals is unlikely to be resolved by future adjudication in those courts.

Because the split on this preemption issue between the Ninth Circuit and the Seventh Circuit is so direct and apparent,

it is unlikely that further adjudication in those courts will help to resolve the conflict. Given the Ninth Circuit's rejection of the reasoning of the Seventh and the Seventh Circuit's firmness in its own view, this is not a matter in which further adjudication might be expected to help illuminate the optimal resolution of the issue. Rather, it is a matter ripe for this Court to resolve.

We note additionally that the courts of appeals have decided a large body of cases attempting to interpret this Court's "arising under" standards set forth in *Salfi* and *Ringer*. Although these cases do not necessarily conflict directly with one another or support directly either of the Ninth Circuit's or the Seventh Circuit's state law preemption determinations, they nonetheless impose a number of varying standards for determining the applicability of § 405(h). *See, e.g., Manakee Professional Medical Transfer Service, Inc. v. Shalala*, 71 F.3d 574 (6th Cir. 1995) (ambulance providers' eligibility challenge arose under the Medicare Act in that the "essence of the claim" was a claim for entitlement to benefits); *Hatcher v. Heckler*, 772 F.2d 427 (8th Cir. 1985) (Medicare claimants' due process challenge arose under the Medicare Act in that their challenge was not "wholly collateral" to a claim for benefits); *American Federation of Home Health Agencies, Inc. v. Heckler*, 754 F.2d 896 (11th Cir. 1984) (Medicare providers' challenge of reimbursement procedures arose under the Medicare Act in that their challenge "eventually did seek" Medicare reimbursement).

It is also worth noting that, although the court denied rehearing, the Ninth Circuit's decision is in apparent and irreconcilable conflict with at least two other decisions rendered by other panels of that court. *See Hooker v. United States Dept. of Health & Human Services*, 858 F.2d 525 (1988) (wrongful death tort claim for consequential damages "arises under" the provisions of the Medicare Act and is thus barred under § 405(h)); *Marin v. HEW, Health Care Financing*, 769

F.2d 590 (1985), *cert. denied*, 474 U.S. 1061 (1986) (negligence claim for consequential damages "arises under" the Act and is barred by § 405(h)). The decision below failed to address either case, which of course raises the question of resolution of conflict with the Ninth Circuit's current position.

In short, further adjudication concerning the *Salfi* and *Ringer* standards, especially in the Seventh and Ninth Circuits, is more likely to produce greater conflict and confusion than it is to yield further insight, let alone harmony. This Court's intervention is thus necessary to resolve the tension within and among the courts of appeal on this issue.

III. THE ISSUE OF PREEMPTION UNDER THE MEDICARE ACT'S GRANT OF EXCLUSIVE ADMINISTRATIVE JURISDICTION IS ONE OF NATIONAL IMPORTANCE, NECESSITATING INTERVENTION BY THIS COURT.

The instant issue of preemption under the Medicare Act is significant and, as an even causal reference to the volume of caselaw on the point demonstrates, likely to recur with increasing frequency in the future. National consistency in the administration of Medicare benefits is an essential and statutorily-dictated feature of this federal program. If claims such as Respondents' are allowed to proceed in state courts, then Medicare benefits determinations will be subject to the vagaries and inconsistencies of local jury decisions around the country. Accordingly, this is an issue of broad and repetitive concern and presents an important question of federal law which this Court should resolve.

A. The uncertainty created by the Ninth Circuit's decision presents a serious hindrance to the effective administration of the statute and regulation at bar.

The Ninth Circuit's decision, if allowed to stand in light of its conflict with *Salfi*, *Ringer*, and *Bodimetric*, would permit Medicare plaintiffs to proceed directly to state court so long as they are shrewd enough not to style their complaints in such a way as to seek the payment of Medicare benefits.

Prior to the Ninth Circuit's holding, the federal courts consistently had safeguarded the need for national uniformity in benefit determinations and generally had upheld the exclusivity of the administrative appeals process established in § 405(h). The Ninth Circuit's decision, though, creates an exception to the jurisdictional bar of § 405(h) that could swallow the rule through the use of artfully drafted pleadings. The federal courts and the state courts should not be subjected to such uncertainty regarding their jurisdictional authority.

Indeed, the decision below could be a license for Medicare beneficiaries to seek consequential and punitive damages in state court against an HMO or other Medicare administrator whenever they dispute a benefit determination, rather than submitting to the jurisdiction of the administrative process. Although the instant case involves a wrongful death claim, the decision would most likely apply to any Medicare beneficiary who alleges consequential damages as a result of an allegedly improper benefit decision. Medicare beneficiaries could thereby avoid the administrative appeals process altogether simply by pleading a claim for emotional distress or other consequential damages rather than seeking payment of

benefits. This would flatly contradict the intention of Congress and would inject the state courts into numerous proceedings that Congress directed exclusively to the HCFA administrative appeals process.

Through this review process, Congress dictated that HCFA (with limited federal court review) is to retain control over and ensures consistency in the administration of Medicare benefits nationwide, regardless of the particular carrier that administers the benefits on a local level. Specifically, Congress incorporated into the Medicare Program, and expressly into the section dealing with HMOs under contract with HCFA, the review procedures found in § 405(g) of the Social Security Act. 42 U.S.C. §§ 405(g), as incorporated into the Medicare Act by § 1395mm(c)(5)(A), (B). These procedures apply to all benefit determinations, including any dispute involving a claimed failure or refusal to provide emergency services such as the air-lift transfer at issue in this case. 42 U.S.C. §§ 405(b), 1395mm(c)(5)(A). *See also* 42 C.F.R. § 417.606.

Echoing the Seventh Circuit's *Bodimetric* decision, a party should not be able to avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for consequential damages instead of a challenge to the underlying denial of benefits. 903 F.2d 487. *See also Salfi*, 422 U.S. at 762 (the jurisdictional bar set forth at § 405(h) "extends to any 'action' seeking 'to recover on any [Medicare] claim' -- irrespective of whether resort to judicial processes is necessitated by discretionary decision of the Secretary").

B. The uncertainty created by the Ninth Circuit's decision will impose continuing consequences on the public at large, not just the litigants.

The Ninth Circuit's decision is one of the first to deal with the preemption issue confronting a health maintenance organization which provides services to Medicare beneficiaries. Over 4.9 million Medicare enrollees, or thirteen percent of the entire Medicare population, are enrolled in such health plans. United States Department of Health and Human Services, Health Care Financing Administration, *Medicare Managed Care Monthly Report Fact Sheet* (January 1997) <http://www.hcfa.gov/medicare/mgdcar.1.htm>. The opinion below throws into question the scope of preemption under § 405(h), the resolution of which is essential to the proper functioning of the federal Medicare program and Medicare's expansion of managed health care programs.

The present case involves the denial of coverage for an airlift transfer. Other cases could involve alleged wrongful denial of coverage for new technologies, or experimental procedures, or investigational drugs, or any number of other benefit issues that must be reviewed consistently to foster uniformity in the federal Medicare program. The Ninth Circuit's holding could impose a significant additional cost if benefit decisions by Medicare HMOs are subject to second guessing by state court litigation and potential claims for consequential and punitive damages. Such a result is clearly inconsistent with the text of § 405(h) which places direct control over HMO benefit determinations with the administrative process in the first instance and to make that appeals process the exclusive avenue for review of benefit determinations.

Finally, it should be noted that the Ninth Circuit's holding here also conflicts directly with court decisions interpreting the preemption provision of the Employee Retirement Income Security Act of 1974 ("ERISA"). *See, e.g., Cannon v. Group Health Service of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir.) *cert. denied*, 117 S.Ct 66 (1996) (insured's surviving spouse claim for negligent or bad faith refusal to authorize autologous bone marrow transplant preempted by ERISA); *Spain v. Aetna Life Insurance Co.*, 11 F.3d 129 (9th Cir. 1993), *cert. denied*, 114 S. Ct. 1612 (1994) (beneficiary's survivors' claim for wrongful death preempted by ERISA); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992) (stillborn child's parents' claim for medical malpractice and emotional distress preempted by ERISA).

Each of these ERISA cases involved a state law action whereby plaintiffs sought to recover damages for an allegedly improper benefit determination. In each of these cases, the court found that plaintiffs' claims were preempted by ERISA despite the fact that the claims were brought under state law theories and despite the fact that plaintiffs sought consequential damages, not plan benefits.

These cases relate directly to the question presented herein because both ERISA and the Medicare Act incorporate similar jurisdictional preemption provisions for cases predicated on a benefit determination. To the extent, then, that the question presented herein has applicability in the ERISA context, the opinion of the Ninth Circuit, which is in apparent conflict with this Court's decisions and with decisions of its sister courts of appeals, potentially affects the adjudication not just of the expanding universe of Medicare claims, but of significant numbers of ERISA claims as well.

CONCLUSION

For the reasons stated, the petition for a writ of *certiorari* should be granted.

Respectfully submitted,

Stuart M. Gerson
Counsel of Record
William A. Helvestine
Michael T. Horan
David M. Pierce
Epstein Becker & Green, P.C.
1227 25th Street, N.W.
Washington, D.C. 20037
(202) 861-0900
Counsel for Petitioners

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT
No. 94-56552

William Ardary; Diane M. Houston;
Kevin Ardary; William C. Ardary, MD,
Plaintiffs-Appellants,

v.

Aetna Health Plans of California, Inc., formerly dba:
Aetna Health Plans of Southern California, Inc.;
Aetna Life & Casualty Company; Aetna Life Insurance
Company; AHP Holdings, Inc.; Aetna Health Management,
Inc.; Partners Acquisition Company; Arrowest Physician
Association; Judith Hendrix,
Defendants-Appellees.

Argued and Submitted April 10, 1996.
Decided Oct. 21, 1996.
As Amended on Denial of Rehearing and
Rehearing En Banc Dec. 26, 1996.

Before: O'SCANNLAIN and TROTT, Circuit Judges, and VAN SICKLE, Senior United States District Judge for the District of North Dakota, sitting by designation.

O'SCANNLAIN, Circuit Judge:

We must decide whether state law claims for wrongful death against a private Medicare provider are preempted by the Medicare Act.

I

William Ardary, Kevin Ardary, William C. Ardary, and Diane M. Houston ("the Ardarys") are the surviving husband and children of the late Cynthia Ardary. In July 1991, William and Cynthia attended a presentation given by Judith Hendrix ("Hendrix"), a marketing representative of Aetna Health Plans of California.[1] Because William and Cynthia resided in the relatively isolated community of Big Bear, California, they expressed concern to Hendrix about emergency care and the availability of more sophisticated treatment. Hendrix allegedly told William and Cynthia that should the need arise, Aetna would immediately authorize transfer to a larger facility such as Loma Linda University Medical Center. As a result of Hendrix's presentation, Cynthia, a Medicare beneficiary, enrolled in Aetna's Senior Choice health maintenance organization plan ("Plan"). The Plan was administered by Arrowest Physician Association ("Arrowest") and provided Medicare, major medical and hospitalization, benefits pursuant to a contract with the U.S. Department of Health and Human Services, Health Care Financing Administration ("HCFA").

On May 9, 1993, Cynthia suffered a heart attack. She was taken to the Bear Valley Community Hospital, a small rural facility near her family's home. The hospital had neither intensive nor cardiac care facilities. The Ardarys allege that in spite of repeated requests from her Aetna-approved physician,

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[1] Aetna Health Plans of California, Inc., formerly dba Aetna Health Care Plans of Southern California, Inc., Aetna Life and Casualty Company, Aetna Life Insurance Company, AHP Holdings, Inc., Aetna Health Management, Inc., Partners Acquisition Company, and Judith Hendrix are collectively referred to herein as "Aetna."

Arrowest refused to authorize airlift transportation for Cynthia to Loma Linda University Medical Center.[2] Allegedly because of Arrowest's failure to authorize the airlift, Cynthia died at Bear Valley.

On January 25, 1994, Cynthia's husband and children filed a wrongful death complaint against Aetna and Arrowest in California state court seeking general and punitive damages on the basis of six state law theories of recovery including negligence, intentional and/or negligent infliction of emotional distress, intentional and/or negligent misrepresentation, and professional negligence.[3] The complaint did not seek recovery

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2 At oral argument, Arrowest claimed that they could not certify the transfer under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.A. s 1395dd. EMTALA imposes two requirements on any hospital which participates in the Medicare program: the hospital must conduct appropriate medical screening to a person visiting its emergency room, and a hospital generally may not transfer out of hospital patient whose medical condition has not been stabilized. Brewer By and Through Brewer v. Miami County Hosp., 862 F.Supp. 305 (D.Kan.1994). Whether Cynthia Ardary was stabilized is, of course, a question of fact.

3 The complaint alleges a cause of action against: (1) Aetna, Arrowest and Hendrix for negligence; (2) Aetna and Arrowest for intentional infliction of emotional distress; (3) Aetna and Arrowest for negligent infliction of emotional distress; (4) Aetna and Hendrix for intentional misrepresentation; (5) Aetna and Hendrix for negligent misrepresentation;

(continued...)

of Medicare benefits; however, the Ardarys conceded that their claims were all "predicated on" Arrowest's failure to authorize the airlift.[4]

In February 1994, Aetna and Arrowest timely removed the action to federal court. They argued that removal was proper on the grounds that federal- question jurisdiction existed because the Ardarys' claims all related to the denial of Medicare benefits and therefore were preempted by federal law. Once in federal court, however, Aetna and Arrowest moved to dismiss the complaint under Fed.R.Civ.P. 12(b)(1) and 12(b)(6) for failure to state a claim, on the ground that the Ardarys' exclusive remedy for their action "relating to" the denial of Medicare benefits was the administrative appeals process provided by HCFA. The district court granted the motion to dismiss in a one-page order that provided no reasons for the court's decision. The Ardarys timely appealed.

II

We first consider the Ardarys' argument that the district court erred in finding that the state law claims all related to the denial of Medicare benefits and therefore were preempted by

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[3](...continued)
and (6) Hendrix for professional negligence. Complaint ¶¶ 23-100.

[4] "It is critical to note in this context that the wrongful death action is predicated on the allegation that the benefits were, in fact, owed and were, in fact, wrongfully denied. Moreover, the plaintiffs in such an action will also be required to demonstrate, at trial, that the wrongful denial of benefits was the proximate cause of the death." Appellant's Brief at 20-21.

the Medicare Act, 42 U.S.C. s 1395, with such claims exclusively administered and reviewed by HCFA.

A

The Medicare Act ("Act") is found in Part A of Title XVIII of the Social Security Act, 42 U.S.C. s 1395 et seq. The Act provides insurance for the cost of hospital and related post-hospital expenses, but precludes reimbursement for services which are not "reasonable and necessary" for the diagnosis or treatment of illness or injury.

Section 405(g) of Title 42, which falls within a different section of the Social Security Act, provides for judicial review of old-age and disability claims only after the Secretary of Health and Human Services renders a "final decision" on the claim.[5] Pursuant to 42 U.S.C. s 1395ff(b), this provision is expressly incorporated into those portions of the Act which apply to HMOs. Pursuant to her rulemaking authority, the

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[5] Section 405(g) reads in relevant part: Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides.... The court shall have power to enter ... a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. 42 U.S.C. § 405(g).

Secretary has provided that a "final decision" is rendered on a Medicare claim only after the individual claimant has pressed his claim through all designated levels of administrative review.[6]

In addition, even when judicial review is available it is strictly limited. Section 1395ii of Title 42 applies the proscriptions of 42 U.S.C. s 405(h) to the Act. Section 405(h) states as follows: The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this

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6 The exclusive administrative appeals process applies to all benefits determinations. 42 U.S.C. § 405(b); 1395mm(c)(5)(A); 42 C.F.R. § 417.606. Such disputes must first be brought for reconsideration to the organization that made the initial determination, 42 C.F.R. § 417.616 and 417.620, and HCFA. 42 C.F.R. § 417.620. If the dispute is not resolved favorably by HCFA, and providing the amount in controversy exceeds $100, a hearing may be requested before an administrative law judge. 42 C.F.R. § 417.630, 417.632. A further appeal may be made to the agency's Appeals Council and, should the amount in controversy exceed $1,000, a dissatisfied party may thereafter seek review in federal court. 42 C.F.R. §§ 417.634, 417.636.

subchapter. 42 U.S.C. s 405(h) (emphasis added).[7] Discussing this provision, the Supreme Court of the United States has held that the appropriate inquiry in determining whether s 405(h) bars federal-question jurisdiction must be whether the claim "arises under" the Act. The Court stated that

> [t]he third sentence of 42 U.S.C. s 405(h), made applicable to the Medicare Act by 42 U.S.C. s 1395ii, provides that s 405(g), to the exclusion of 28 U.S.C. s 1331, is the sole avenue for judicial review of all "claim[s] arising under" the Medicare Act. Thus, to be true to the language of the statute, the inquiry in determining whether s 405(h) bars federal-question jurisdiction must be whether the claim "arises under" the Act.... Heckler v. Ringer, 466 U.S. 602, 614-15, 104 S.Ct. 2013, 2021, 80 L.Ed.2d 622 (1984) (internal citations omitted).

B

This case presents a thorny jurisdictional question: does the Medicare Act, which provides for exclusive administrative review of all claims "arising under" that Act, apply to preclude the heirs of a deceased Medicare beneficiary from bringing state law claims for wrongful death against a private Medicare provider when those claims do not seek recovery of Medicare benefits but instead seek compensatory and punitive damages on the grounds that the provider both improperly denied emergency

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[7] Section 405(h) thus makes § 405(g) the sole avenue for judicial review of all "claim[s] arising under" the Medicare Act.

medical services and misrepresented its managed care plan to the beneficiary?[8]

Resolution of this question turns on whether the state law claims are ones "arising under" the Act. Aetna and Arrowest argue that the entire complaint "arises under" the Act because the Ardarys' claims all relate to a dispute concerning the denial of Medicare benefits.[9] Aetna and Arrowest also maintain that "[t]he courts similarly left no doubt that the Medicare Act precludes all types of civil litigation outside the administrative appeals process" in this case. Appellee's Brief at 12. We disagree with this over-inclusive reading of the "arising under" language.

First, the Ardarys' complaint does not "include any claims in which 'both the standing and the substantive basis for the presentation' of the claims" is the Act. Heckler v. Ringer, 466 U.S. 602, 615, 104 S.Ct. 2013, 2021-22, 80 L.Ed.2d 622 (1984) (citing Weinberger v. Salfi, 422 U.S. 749, 760-61, 95 S.Ct. 2457, 2464-65, 45 L.Ed.2d 522 (1975)) (emphasis added). The Ardarys seek general and punitive damages on the basis of negligence, intentional and/or negligent infliction of emotional distress, intentional and/or negligent misrepresentation, and professional negligence. The standing for these six claims are state common law theories and not the Act. Second, the state law claims are not "inextricably

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8 The parties do not cite any cases directly addressing the question raised in this case.

9 Aetna and Arrowest frame the issue as "whether Congress intended to allow the state court actions challenging Medicare benefits determinations when it barred such actions in federal court." Appellee's Brief at 12.

intertwined" with the denial of benefits. Although the Ardarys concede that their wrongful death complaint is "predicated on" Arrowest's failure to authorize the airlift transfer, the claims are not "inextricably intertwined" because the Ardarys are at bottom not seeking to recover benefits. Ringer, 466 U.S. at 614, 104 S.Ct. at 2021. In contrast, the Court in Ringer observed that [i]t seems to us that it makes no sense to construe the claims of those three respondents as anything more than, at bottom, a claim that they should be paid for their BCBR surgery. Arguably respondents do assert objections to the Secretary's "procedure" for reaching her decision--for example, they challenge her decision to issue a generally applicable rule rather than to allow individual adjudication, and they challenge her alleged failure to comply with the rulemaking requirements of the APA in issuing the instructions and the rule. We agree with the District Court, however, that those claims are "inextricably intertwined " with respondents' claim for benefits. Id. (emphasis added).

Although the Supreme Court in Ringer instructed us to read the term "arising under" broadly, it "recognized that in certain special cases, deference to the Secretary's conclusion as to the utility of pursuing the claim through administrative channels is not always appropriate." Id. at 618, 104 S.Ct. at 2023. For instance, the Court commented on one such case, "where the plaintiff asserted a procedural challenge to the Secretary's denial of a pretermination hearing, a claim that was wholly 'collateral' to his claim for benefits, and where he made a colorable showing that his injury could not be remedied by the retroactive payment of benefits after exhaustion of his administrative remedies." Id. (citing Mathews v. Eldridge, 424 U.S. 319, 330-32, 96 S.Ct. 893, 900-01, 47 L.Ed.2d 18 (1976)). Aside from the conclusion that the Ardarys' state law tort claims are not "inextricably intertwined" with benefit determinations, Cynthia's death also cannot be remedied by the retroactive authorization or payment of the airlift transfer.

Aetna and Arrowest argue that Bodimetric Health Services, Inc. v. Aetna Life & Casualty, 903 F.2d 480 (7th Cir.), cert. denied, 498 U.S. 1012, 111 S.Ct. 579, 112 L.Ed.2d 584 (1990), should be read for the proposition that any claim related to the denial of Medicare benefits "arises under" the Act. In that case, Bodimetric Health Services owned and operated home health agencies ("HHAs") that provided in-home medical services. All of the HHAs were certified as Medicare providers which obtained their reimbursements for the medical services from fiscal intermediaries which acted on behalf of HCFA. Pursuant to 42 U.S.C. s 1395h, Bodimetric nominated Aetna to serve as its fiscal intermediary. Under this situation, Aetna provided Medicare reimbursement to Bodimetric's HHAs for services rendered.

Bodimetric alleged that in 1985, the Secretary released a contractor evaluation critical of Aetna's performance. Bodimetric alleged that because of this evaluation, Aetna started regularly to deny Bodimetric's applications for reimbursement so that Aetna would improve its contract performance evaluation and retain its contract with HCFA as a fiscal intermediary. Because of the denials, Bodimetric lost $8 million. Bodimetric then sued Aetna, seeking damages for fraud and other tort causes of action. Aetna moved to dismiss for lack of subject matter jurisdiction, alleging that the exclusive review provisions of the Act barred Bodimetric from pursuing its challenge in federal court, and the district court granted the motion. On appeal, the Seventh Circuit stated that the issue was "whether the allegedly improper application of 'exclusive' review mechanisms to Bodimetric's claim is actionable in the district court." Id. at 482.

The Seventh Circuit noted that "whether Bodimetric's claim for damages is inextricably intertwined with a claim for Medicare benefits or wholly collateral to such a claim (or somewhere in between) depends largely on whether this appeal

more closely resembles United States v. Erika, 456 U.S. 201 [102 S.Ct. 1650, 72 L.Ed.2d 12] (1982) or Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 [106 S.Ct. 2133, 90 L.Ed.2d 623] (1986)." Id. at 484. In Erika, "the Court held that section 1395ff barred judicial review of a hearing officer's 'amount of benefits' determination under Part B of the Medicare Act." Id. However, in Michigan Academy, "the Court concluded that section 1395ff does not bar judicial review of claimant challenges to the validity of administrative regulations promulgated under the Medicare Act." Id. We conclude that the Ardarys' state law claims do not fall under either of the two types of claims reviewed in Erika and Michigan Academy.

The Seventh Circuit concluded that "Erika and Michigan Academy recognized the differences between two types of Medicare claims: challenges to the amount of benefits to be paid are not reviewable, while challenges to the regulatory scheme under which the amount of benefits is calculated are reviewable." Id. at 485. Although the Seventh Circuit properly identified the "differences between two types of Medicare claims," the Supreme Court's decisions in Erika and Michigan Academy certainly do not suggest, at least to this court, that this dichotomy (substantive or procedural) is the standard for making the critical judgment call about what "arises under" the Act. It should be stressed that the Supreme Court has already rejected that "separation of the particular claims ... into 'substantive' and 'procedural' elements." Ringer, 466 U.S. at 614, 104 S.Ct. at 2021.

Without clear guidance from the Supreme Court or Congress on these facts, we must begin with the strong presumption that Congress does not intend to pre- empt state law causes of action with a federal statute. See, e.g., Medtronic, Inc. v. Lohr, --- U.S. ---- ----, 116 S.Ct. 2240, 2250, 135 L.Ed.2d 700 (1996) ("[B]ecause the States are

independent sovereigns in our federal system, we have long presumed that Congress does not cavalierly pre- empt state-law causes of action."); Cipollone v. Liggett Group, Inc., 505 U.S. 504, 516, 112 S.Ct. 2608, 2617, 120 L.Ed.2d 407 (1992) ("[S]tate law is pre-empted if the law actually conflicts with federal law."); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947) ("[S]tart with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."). We find nothing in the legislative history to suggest that the Act was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA. See Michigan Academy, 476 U.S. at 679-80, 106 S.Ct. at 2140-41. Indeed, the "legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto provides specific evidence of Congress' intent to foreclose review only of 'amount determinations'--i.e., those 'quite minor matters,' 118 Cong.Rec. 33992 (1972) (remarks of Sen. Bennett), remitted finally and exclusively to adjudication by private insurance carriers in a 'fair hearing.' " Michigan Academy, 476 U.S. at 680, 106 S.Ct. at 2141.

We are most reluctant to adopt Aetna and Arrowest's over-inclusive reading of the "arising under" language "without a showing of clear and convincing evidence to overcome the strong presumption that Congress did not mean to prohibit all judicial review." Id. (citations omitted). Absent a strong argument from Aetna and Arrowest, this presumption still remains in force.

Contrary to Aetna and Arrowest's assertions, Bodimetric should not be taken to imply that private Medicare providers and their representatives cannot be held responsible in their individual capacity for tortious acts committed in the context of

the denial of Medicare benefits. The removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients. Aetna and Arrowest's argument that the claims are "inextricably intertwined" with the claim that Cynthia was improperly denied benefits simply misapplies Ringer and Bodimetric on these facts.

Because the instant state law claims do not "arise under" the Act, we hold that the exclusive administrative procedures outlined for resolution of benefit determinations do not preempt the Ardarys' complaint.

III

We next consider whether the district court erred in removing the action to federal court. The Medicare statutes, as applied to an HMO contract, do not, of course, contain a preemption provision. The Ardarys argue that the district court was without jurisdiction because there was no federal statutory preemption of their state law claims, and therefore no substantial federal question was raised. Because we hold that the Ardarys' state law claims do not "arise under" the Medicare Act, we must conclude that the action was improperly removed to federal court. Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 66, 107 S.Ct. 1542, 1547-48, 95 L.Ed.2d 55 (1987).

IV

For the foregoing reasons, the district court's judgment is reversed, and this case is remanded with instructions to the district court to remand the action to state court for further proceedings.

REVERSED and REMANDED with instructions.

APPENDIX B

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

WILLIAM ARDARY, ET AL.,	) CF 94-1235 JSL
	)
Plaintiffs,	) ORDER GRANTING
	) DEFENDANTS'
v.	) MOTION TO
	) DISMISS
AETNA HEALTH PLANS OF CALIFORNIA, INC., ET AL.,	)
	)
Defendants.	)
	)

The Motion of defendants Aetna Health Plans of California, Inc., et al. to dismiss came for hearing regularly on March 28, 1994.

Having reviewed the papers filed in connection with this matter, having heard oral argument, and being fully apprised of the relevant facts and law,

IT IS HEREBY ORDERED that the motion of defendants Aetna Health Plans of California, Inc., et al. be GRANTED.

IT IS SO ORDERED.

DATED: 5/23/94

/s/
J. Spencer Letts
United States District Judge

APPENDIX C

NOT FOR PUBLICATION
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

WILLIAM ARDARY; DIANE M. HOUSTON; KEVIN ARDARY; WILLIAM C. ARDARY, MD, Plaintiffs-Appellants,	)	No. 94-56552 D.C. No. CV-94-01235-JSL
v.	)	
AETNA HEALTH PLANS OF CALIFORNIA, INC., formerly dba: AETNA HEALTH PLANS OF SOUTHERN CALIFORNIA, INC.; AETNA LIFE & CASUALTY COMPANY; AETNA LIFE INSURANCE COMPANY; AHP HOLDINGS, INC.; AETNA HEALTH MANAGEMENT, INC; PARTNERS ACQUISITION COMPANY; ARROWEST PHYSICIAN ASSOCIATION; JUDITH HENDRIX, Defendants-Appellees.	)	ORDER

Before: O'SCANNLAIN, Circuit Judge:

Appellee's motion for stay of mandate pending petition for certiorari to the Supreme Court of the United States is GRANTED pursuant to Fed. R. App. P. 41(b).